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AIDS: Legal Issues of Federal Concern

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AIDS: LEGAL ISSUES OF FEDERAL CONCERN

INTRODUCTION

Acquired Immunodeficiency Syndrome (AIDS) is a communicable, incurable, fatal disease that in a very few years may become the most common cause of death for Canadian men between the ages of 20 and 39. AIDS, however, is more than just a disease. Spreading out from its medical effects, and the widespread fear they have produced, are social, economic and legal ramifications that pose challenges of their own. The purpose of this review is to examine some of the legal implications of the medical and social phenomenon that is AIDS. The review will deal only with matters of concern to federal legislators, although these issues are perhaps less significant in the overall picture than those which will be dealt with by provincial authorities. A comprehensive review of all the legal questions which legislators and governments in Canada may at some point have to face as a result of the spread of AIDS is beyond the scope of a survey of this length.

MEDICAL FACTS

AIDS is the name given to the terminal form of an infection that is caused by a virus, the human immunodeficiency virus (HIV), which attacks the body's immune system. Although the virus is believed to have existed in the 1950s, the disease was not identified until 1981. Experience with the disease has thus been very short. Notwithstanding its recent appearance, medical understanding of the disease has advanced very rapidly.

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Even so, there is much yet to be learned. The medical findings set out below, upon which the comments and opinions expressed in the paper are based, represent the preponderance of scientific opinion on the evidence amassed to date. This opinion is reflected in reports of the World Health Organization, the Surgeon General of the United States, and the Federal Centre for AIDS in Canada, among others. It must be borne in mind, however, that it has only been seven years since the disease was first diagnosed, and some of these findings may change as more experience with the disease brings forth new evidence. As scientific knowledge develops and changes, the nature of the appropriate legal responses may also change, but they should nonetheless be based on the preponderance of scientific opinion as it exists at any given time.

A. AIDS and HIV Carriers

Not everyone infected with the HIV virus has or necessarily will develop AIDS. Of those who are exposed to the virus and carry it in their bloodstreams some may have no symptoms and others may develop only mild symptoms. A large number of those infected - on the basis of present experience it would appear to be at least 35% - will ultimately develop full-blown AIDS over an average period of five to six years.

The medical threat is thus like an iceberg -- for every person showing detectable signs of the disease there are possibly 10 or more people infected with the virus who have no symptoms at all. It is the existence of this hidden group of HIV carriers, rather than the disease itself, that has engendered most of the fear. It is also this group around whom most of the legal issues revolve. In Canada up to 50,000 people are at present estimated to have been infected, and the estimates may continue to rise.

B. Transmission of HIV

There is no evidence that HIV infection can be spread through casual contact in any setting, whether household, social, work, school or prison. The virus is transmitted when blood, semen or vaginal fluids from an infected person enter the bloodstream of another person.

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The virus has been detected in tears, urine, saliva, and other bodily fluids but there are no documented cases of transmission by these means. The quantity of virus in these fluids may be too small to transmit the infection, and most experts have concluded that the possibility of this is too remote to constitute a significant risk.

The ways in which the HIV virus is transmitted are:

- by vaginal or anal intercourse with an infected person;
- by sharing contaminated needles or syringes;
- from an infected mother to her child;
- through transfusions of infected blood or blood products;
- through organs transplanted from infected donors.

Sexual intercourse which involves the exchange of semen or vaginal fluids accounts for the vast majority (almost 90%) of diagnosed cases of AIDS in Canada. Anal intercourse constitutes a particularly high risk sexual activity, and men who engage in homosexual and bisexual activity are currently at greatest risk in Canada. In parts of Central Africa, in contrast, heterosexual intercourse is the primary source of transmission.

In Canada all blood products used by hemophiliacs are now heat treated to render any HIV virus inactive. Blood donors are being screened for HIV antibodies and screening is also carried out on prospective organ and semen donors. Although these tests are not an absolute guarantee, it is believed that the blood supply is now safe for all reasonable purposes. Cases of AIDS incurred by these means have constituted less than 5% of the total in the past, and should become increasingly rare in the future.

Transmission of the virus through sharing of contaminated needles and syringes by intravenous drug users has been the least significant source of infection in Canada, comprising less than 1% of documented cases. In the United States, up to 25% of cases are attributed to this source. One can only speculate about the causes of this discrepancy, but drug abuse in Canada may not be as widespread as it is in

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the United States, and there are fewer controls in Canada on the purchase of needles and syringes by individuals.

AIDS is a disease that is spread by specific forms of behaviour that can be clearly defined and that, while commonplace, are open to self-control and modification by public education programs, and perhaps to deterrence through the application of criminal law. The debate that has emerged is over whether the only effective way to modify the behaviour is through public education and private counselling of infected persons and people involved in high risk activities, so that the individuals who pose a risk of transmission will voluntarily control their own behaviour, or whether the state should try to control the spread of the virus through the use of powers such as mandatory testing and the criminal law.

CONSTITUTIONAL JURISDICTION

In constitutional terms, "health" is an amorphous topic that may be addressed by either the federal Parliament or the provincial legislatures, depending on the nature of the health problem in issue. Either level of government may deal with health matters when enacting legislation directed to an express head of power under sections 91 and 92 of the Constitution Act, 1867. The provinces may do so when legislating in regard to public hospitals (section 92(7)). The federal Parliament may certainly enact prohibitions and penalties concerning conduct which harms the public pursuant to its criminal law power (section 91(27)).

While there is no specific head of power in either section 91 or 92 dealing with the protection of public health, it is nonetheless also true that general provincial jurisdiction over health matters has been recognized over time and has been affirmed by the Supreme Court of Canada, based on the provinces' power over property and civil rights (section 92(13)) and local or private matters (section 92(16)). Because of this jurisdiction, the provinces have created statutory law and administrative structures that regulate all aspects of public health. They are thus better equipped to deal with most of the challenges that AIDS poses.

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The provinces' general jurisdiction over matters of public health, however, would not prevent the federal government from legislating in regard to a health problem that had attained a "national dimension" or one that had reached the level of a national emergency. These are the terms developed by the courts to express the scope of the residual power of the federal Parliament to legislate under section 91 for "peace, order and good government."

Although AIDS in a medical sense would appear to have reached the level of an epidemic, the number of cases to date may not be sufficient to justify, in constitutional terms, federal legislative action on the basis of a national emergency. If, however, a large percentage of those who are at present thought to be infected eventually develop the disease, and if infection continues to spread, an undeniable state of national emergency might well exist in the not too distant future.

On the other hand, public health education will remain the principal weapon in the fight against AIDS, and provincial programs may be sufficiently effective that a single national program will not become an overriding necessity, although it may nonetheless be desirable.

Public education is, however, primarily a matter of funding, and much of this funding may eventually have to come from the federal government. Medical treatment of AIDS sufferers will consume an ever greater percentage of provincial health budgets, and there will undoubtedly be pressure for federal help in dealing with these costs as well. Federal involvement in the problem of AIDS will thus primarily involve the use of the spending power, rather than legislative power. If national standards are necessary in regard to such matters as antibody testing, particularly as the AIDS threat grows, the federal government will likely be in a position to establish such standards through coordination efforts alone.

TESTING ISSUES FACING FEDERAL AUTHORITIES

Routine testing procedures will neither catch all those who have been infected, nor detect the presence of infection (in the form of HIV antibodies) with absolute reliability. Because of the stigma of AIDS,

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and the grave social consequences which may ensue for people labelled as being infected, great care must be taken in implementing and administering any testing program. The tests used to detect infection are those which look for the presence of antibodies produced in response to invasion by the virus. The initial screening tests produce a significant number of false positives and some false negatives. To reach an acceptably high degree of reliability, a series of tests is normally carried out to confirm any positive results. Even routine testing thus involves significant time and expense. It may also take up to six months after infection for the antibody to show up in a test. Anyone who tests positive for the antibody is presumed to be capable of transmitting the virus to others.

The questions of when and whom to test for HIV antibodies, what to do with test results, and whether to institute programs of mandatory testing, are perhaps the most critical AIDS issues facing lawmakers and public health authorities. Most of these issues will be faced by provincial authorities, but because of its jurisdiction over particular groups of people the federal government will confront some specific questions of whether to institute mandatory testing. In general it should be said that mandatory testing in any form is not considered by the World Health Organization, or by its national affiliated bodies in Canada and the United States, to be of any aid in controlling the spread of the disease.

A. Immigrants

Although Canada does not accept prospective immigrants if they have AIDS, there is no routine test for HIV antibodies as part of immigration medicals. In December 1987, the United States instituted mandatory HIV antibody testing for all would-be immigrants, and the Canadian government is monitoring its system. To date, opinion remains divided on whether Canada should follow the American example. The Immigration Medical Review Board, an advisory body to the Assistant Deputy Minister of Health and Welfare in matters relating to medical standards and practices in immigration, has recommended in favour of mandatory testing. The National Advisory Committee on AIDS, however, is currently not in favour of testing, nor is the Royal Society of Canada.

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The difficulty with treating people infected with the HIV virus as medically inadmissible is that they have no disease, and perhaps a significant proportion of them will not develop AIDS. We have no way of predicting the likelihood that infection will progress to disease in any particular case. There must thus be an element of arbitrariness in rejecting any infected applicant on the basis of statistical probabilities. The testing procedures also involve a significant cost, and in order to avoid possibly discriminatory application, would have to be routinely required of all applicants, whether or not the disease was a problem in their home country. In many parts of the world, testing facilities would not be available. On the other hand, the cost of treating an AIDS patient is very high, and those who did go on to develop the disease would impose substantial costs on our health care system. The likelihood of such costs leads to the rejection of applicants with other forms of disease or medical disability. Of course, there remains the fact that HIV-infected immigrants could also contribute to the spread of the disease in Canada.

The Canadian Bar Association-Ontario AIDS Committee examined the foregoing arguments and concluded in a Report that mandatory testing should be implemented. The Committee recommended that consideration of immigration applications from those testing positive be deferred for three years and then reconsidered. In countries where facilities for such testing are not adequate, the Report recommended that they be set up in connection with Canadian embassies.

B. Prison Inmates

In many ways, prison inmates might appear to be a likely target group for a mandatory HIV antibody testing program. Literally a captive population, they are subject to a variety of decisions made by correctional authorities as to what is necessary for the proper management of prisons. Should those authorities decide that HIV antibody testing was necessary on intake or during incarceration to protect the health of the inmate population, or before release in order to protect the general

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population, it might be assumed that there would be little in the way of practical or legal impediments.

Ironically, it was in the prison setting that the Canadian Charter of Rights and Freedoms was first used to declare invalid a pilot project of mandatory drug testing, and the principles of that decision would also be relevant to an HIV antibody testing program. In Re Dion and the Queen (1986), 30 C.C.C. (3d) 108 (P.Q.S.C.), it was found that random demands for urine samples to detect drug use violated the inmates' rights to life, liberty and security of the person under section 7 of the Charter. Because there was no requirement that there be reasonable and probable grounds for demanding a sample, the power was held to be arbitrary and thus contrary to the principles of fundamental justice and not reasonably justifiable under section I of the Charter. The decision has been appealed, but for the foreseeable future it will stand as an argument against any large-scale AIDS testing program in prisons.

A number of other arguments have been advanced by commentators against the suggestion that mandatory testing be implemented in prison settings. Confidentiality would be very difficult to maintain, and an inmate identified as being infected would be at risk of harm from the prison population. There would also appear to be little the correctional authorities could do upon learning that an inmate was infected besides segregating him or her in an isolation unit, but mandatory isolation could also be challenged as a Charter violation.

The Royal Society of Canada has advocated that condoms be issued to inmates and the same suggestion has been made in the United States and Australia. The answer from Canadian correctional authorities was the same as from such authorities elsewhere -- an unequivocal no. As condoms are only of use if the inmates are breaching prison rules by engaging in sexual behaviour, prison authorities fear that supplying them would compromise institutional discipline. Some commentators assert that homosexual activity in prisons is a major problem and that the risk of the disease spreading in prison is thus sufficient to make mandatory HIV antibody testing necessary and justify the overriding of Charter rights. It is difficult, however, to imagine correctional authorities arguing for

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recognition of such a problem. Thus, both for practical and legal reasons, it is unlikely that such testing programs will be implemented in Canadian prisons.

C. Armed Forces

Although HIV infection does not affect a person's ability to perform any employment task, the United States Government at present tests some employees for HIV antibodies. The U.S. Army tests all recruits and bars entry to anyone testing positive. The justification for such action is that all soldiers must be known to be free of infection because of the need for battlefield transfusions in times of war. On the other hand, in its discussion of this issue, the Canadian Bar Association-Ontario AIDS Committee Report notes that the use of blood-expanding products makes such transfusions now largely unnecessary.

The Canadian Forces have stated that they have no intention of following the American example.

CRIMINAL LAW

A. The Limits of the Criminal Law

Criminal cases in the United States and Canada involving AIDS have caused great concern among the Canadian public and led to calls for greater use of the criminal law power to protect the public health. Some of these cases involved infected prostitutes who continued their activities after it became known that they were carriers of the virus. One controversial Canadian case involved a man who donated blood knowing that he was infected and a similar American case involved the sale of infected blood. While both types of cases have focused greater concern on the role of the criminal law in halting the spread of AIDS, they also illustrate the limits of the criminal law as a weapon in this battle.

Concern about AIDS transmission by prostitutes has been highlighted when women charged with soliciting and known to be infected with the HIV virus have been released on bail on condition that they

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refrain from behaviour likely to spread the virus. Their release raised questions among the public, and there were calls for denial of bail and continued detention to prevent a threat to public health.

The power to detain someone pending his or her trial on a charge under the Code, however, is not intended to be a general power of preventive detention based on a concern for the potential spread of a communicable disease. Its purpose is either to ensure that the accused will appear for trial or to safeguard the public. This latter ground for detention normally relates to the likelihood that the accused will commit another criminal offence. It is difficult to imagine a detention order being upheld if the danger feared involved no illegal act on the part of the accused. Such a detention could only be a temporary stopgap measure in any event. A prostitute who found herself or himself detained until trial could avoid this detention simply by pleading guilty or otherwise forcing an early trial. The legal issue would then shift solely to the question of the criminal charge itself.

Nor does a charge under the Criminal Code aimed at the behaviour that transmits the disease ensure that the infected person will be prevented from ever again posing a risk. The Canadian blood donation case brought a charge of being a criminal common nuisance, thereby endangering the lives, safety or health of the public. This charge is punishable by imprisonment for a maximum of two years. If convicted, the accused may be punished for what he has done and, it is hoped, others may be deterred from similar conduct. The criminal law can thus seek to mould behaviour through fear of punishment. But the accused will not and cannot be held liable for what he may do in the future. The criminal law can only punish actual behaviour committed with the requisite criminal intent.

The one exception to this general principle is the Criminal Code provision for indeterminate imprisonment of "dangerous offenders." Although it may amount to preventive detention in some sense, this power is available only upon sentencing for a violent offence, and requires proof of a persistent pattern of violent criminal behaviour sufficient to justify a sentence of indeterminate life imprisonment. It would not, in any case, apply to the behaviour that spreads the HIV virus.

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Preventive detention based on a threat to the public health, therefore, may be sustained only as a power of isolation (commonly known as "quarantine"), and this is a challenge that will be faced by provincial public health authorities. Because of the unusual characteristics of the HIV virus, detention for the purposes of isolation may not be an appropriate means of dealing with the threat of its spread, and moreover may not be legally justifiable. These are challenging issues in their own right, but are beyond the scope of this paper. Whatever may be the suitability and defensibility of isolation as a response to HIV infection, it appears to be the only approach that will allow detention to be based on the potential for future harm.

B. Existing Offences

There are several basic elements of criminal liability that apply to all criminal offences. The most important is the requirement that the offender have a guilty mind, or criminal intent. Another is the question of causation. Where the offence produces particular harmful consequences, it must be shown that it was the act of the accused that resulted in such consequences. The definition of the prohibited conduct must be clear enough for people to know exactly what it is they must not do. The prohibition must also be enforceable.

The principles of intent and causation make it particularly difficult to apply existing criminal offences to the problem of HIV transmission. A specific intent to cause someone harm will perhaps rarely be present in HIV transmission cases. Indeed, much of the sexual activity which risks transmission of the virus will be part of ongoing intimate relationships. The infected state may be hidden from the partner for fear that the relationship would end or because the partner would learn of sexual misconduct by the infected person. Casual sexual activity will often reflect only indifference regarding the potential for transmission, and at worst will involve a reckless disregard for the consequences to others. Needle-sharing by intravenous drug users would in most cases probably involve little more than simple negligence.

The cases involving sale or donation of infected blood, such as the Canadian case referred to earlier, would appear to involve a high

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level of criminal intent. The only motive in that incident appears to have been a desire to hurt others. This may indeed have been the case, although the accused has been reported as saying that he thought donating blood would lessen his chances of developing the disease. Even if believed, this intent would amount to reckless disregard for the safety of others, but would not involve a specific intent to harm; and indeed, the charge of common nuisance which was laid would appear to reflect this. Cases involving intentional donations of infected blood are in any case likely to be very rare.

Barring, then, the rare case involving blood donations or sexual activity motivated by an irrational desire to hurt others which some HIV-infected persons have apparently expressed, most cases which exhibit a high level of criminal intent are likely to involve prostitutes who continue to work after learning that they are infected, and promiscuous sexual activity in which the infected persons do not advise casual contacts of their infected state. These cases will also pose the greatest risk of the virus being spread. The intent involved will generally be what the law defines as "recklessness" -- a "wanton and reckless disregard" for the lives or safety of others. The application of this level of criminal intent to HIV transmission is complicated by the question of causation. The criminal law has normally punished people for acts involving reckless intent only when actual harm to another person could be shown. The nature of AIDS as a disease makes this extremely difficult. The American authorities have resorted in one case to a charge of "attempted" manslaughter. It is difficult to imagine, however, a prosecution based on someone's "attempt" to show "wanton and reckless disregard" for the lives of others.

The charge of criminal common nuisance that has been laid in the Canadian blood donor case does not require that anyone actually be harmed; it is based rather on conduct that "endangers the lives, safety, health, property or comfort of the public." The offence is committed, however, only when someone does "an unlawful act" (presumably the act must be prohibited by another law) or "fails to discharge a legal duty" and thereby endangers the public. This offence may therefore be of limited

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utility and we shall have to wait and see whether the prosecution of the blood donor case is successful.

The Law Reform Commission of Canada has recommended that a new offence of "reckless endangerment" be included in a revised Criminal Code. Such an offence would probably catch at least the more egregious AIDS cases involving wanton disregard for the lives of others. Another option is the development of an AIDS-specific offence.

C. An AIDS-Specific Offence

Several American states and most of the Australian states have either enacted or are considering creating an offence specifically designed to deal with AIDS. Most of these provisions are directed solely at sexual contact and make it an offence to engage in various sexual acts that pose a risk of transmission without advising the partner of the risk. In some cases it is required that the infected person obtain the partner's "informed consent," although it is unclear what sort of evidence would be required to prove that the partner was sufficiently knowledgeable about the risk. The focus of these offences is thus on deception by the infected person, which puts the partner at risk without his or her knowledge. So long as the partner voluntarily assumes the risk there is no offence.

In other cases, any sexual activity involving infected persons is criminalized, regardless of whether the other party assumes the risk or not. Even intercourse between two infected persons would offend such a provision. It may be questioned whether criminal prohibitions that demand complete abstinence, and make sexual relationships between consenting adults an offence, will be enforceable.

These AIDS-specific offences avoid most of the problems involving intent and causation that arise when traditional criminal offences are applied to HIV transmission. Although most of them apply only to sexual activity, it is this activity that is primarily responsible, and in Canada almost totally responsible, for the spread of the virus. By clearly identifying the prohibited behaviour and concentrating on the element of disclosure, they perhaps stand the best chance of being successful in moulding behaviour so as to combat the spread of AIDS.

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Those experts who have advocated the development of AIDS-specific offences have generally proposed that disclosure be the principal objective. Some have also suggested that it be an offence for infected persons to engage in sexual activity without using all reasonable precautions, so as to provide reinforcement for public health campaigns for "safe sex." To date, no provisions including this element appear to have been developed.

D. The Case Against the Use of Criminal Law

Public health authorities, legal advisory bodies and other commentators here and abroad have generally recommended against the application of criminal law to the problem of HIV transmission. In Canada, this view is shared by the Canadian Bar Association-Ontario Committee on the Legal Implications of AIDS, the Royal Society of Canada, and others. Some of those opposing the use of criminal sanctions doubt the deterrent value of criminal law, given that the activity involved is sexual behaviour that is otherwise accepted or at least tolerated by the majority of people. Others acknowledge that use of criminal sanctions might have some deterrent effect, but fear that it could lead to discriminatory harassment of homosexual men, a general invasion of the privacy of a great many citizens, or other infringements of basic civil liberties.

The most disturbing question raised by opponents of a criminal law response to AIDS is whether its use would be counterproductive in the battle against the disease. Unlike other sexually transmitted diseases, AIDS is untreatable, and there is thus less reason for those who fear they may be infected to seek medical confirmation. Contact tracing may also be an important element in dealing with AIDS transmission, and cooperation by those found to be infected may be discouraged if they fear it may lead to criminal investigations or charges. Since criminal liability would not attach unless the person was aware that he or she was infected, the enforceability of the law itself will depend on those infected undergoing voluntary testing. Paradoxically, fear of criminal prosecution could deter people from undergoing the necessary tests. There appears to be unanimous agreement among public health authorities and

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other experts that voluntary testing, sought out by those in high risk groups at as early a point as possible, and non-coercive treatment and counselling of those found to be infected, promise the best chance of slowing and eventually halting the spread of AIDS.

ANTI-DISCRIMINATION LEGISLATION

The federal Canadian Human Rights Act and the various provincial human rights codes protect individuals against discrimination in a number of areas, including employment and the provision of accommodation and goods and services. One of the prohibited grounds of discrimination is handicap or disability. These terms are defined to include "infirmity" or "illness," so they clearly would cover discrimination which occurred because a person had developed AIDS.

A question arises, however, about discrimination based on a knowledge or belief that someone has tested positive for HIV antibodies. As noted earlier, such individuals may be asymptomatic for years, and some may never develop the disease. Would discrimination on this basis be prohibited under human rights legislation?

Where the discrimination is based on a fear that HIV infection means that the infected person has AIDS or will inevitably develop the disease, the legislation will probably apply. Some provincial Codes cover this situation expressly. The Ontario statute provides that where "the person ... is believed to have" a handicap discrimination is prohibited. The federal Act does not contain a comparable provision, but case law indicates that it will protect someone against discrimination on the basis of a perceived "disability."

Much of the discrimination against people infected with the HIV virus is based, however, not on a belief that they have the disease itself, but on the mistaken belief that they are capable of transmitting the virus through some form of non-intimate contact and that they therefore pose a risk to the general public. Will the legislation protect HIV-infected people, or those believed to be HIV-infected, from discrimination on this basis?

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The Canadian Human Rights Commission has recently announced that it will deal with complaints that allege discrimination on the basis of HIV infection alone. Whether this interpretation of the Act will be supportable remains to be seen. Invasion of the body by the HIV virus does not, as noted, quickly result in the development of disease, and it is not certain that all of those infected will eventually suffer from AIDS. Infection with the HIV virus does not necessarily equal "illness." The courts may uphold the Commission's policy by equating "illness" with the presence of a virus which will likely result in the development of a disease, or simply with the ability to transmit the cause of disease to others, but it may be necessary to re-examine the Act with a view to clarifying and strengthening it.

The Commission has also declared that it will deal with discrimination based on an assumption that someone is HIV-infected because of his or her membership in a group associated with the disease, or on a person's association with someone who is infected (family members will in particular be protected). The groups involved, however, may only include those based on the characteristics at present protected under the Act - sex, race, colour, or national or ethnic origin. While this will protect people who come from places where the disease is or is believed to be endemic, such as Haiti, it will not afford any protection to the vast majority of those in the high risk category - homosexual and bisexual men. The question of whether to amend the Act to prohibit discrimination based on sexual orientation, raised before at the federal level, may now become more acute.

The most controversial of the new policies announced by the Commission involves the definition of when discrimination in employment is permissible - the bona fide occupational requirement. Since medical experts agree that HIV infection cannot be spread by casual contact, there would appear to be no justifiable basis for discriminating in employment, or in any other public situation, against someone who is merely infected with the HIV virus and has no debilitating symptoms. The Commission has affirmed that employer or employee preference based on a fear of AIDS is not an acceptable basis for discrimination. It has, however, declared that

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it will consider freedom from HIV infection to be a bona fide occupational requirement in the following circumstances: 1) where the employee performs "invasive procedures" (health care workers such as surgeons); 2) where the job requires travel to countries which bar entry to anyone infected with the HIV virus; and 3) where the employee's job affects the safety of the public and he or she works alone. The policy means that mandatory testing will be acceptable in these cases.

The second of the three situations described by the Commission may appear to be a reasonable basis for a bona fide occupational requirement. The announcement states that there are countries which bar entry to those who "have tested" HIV antibody positive. There would appear, however, to be only a very few countries that require evidence that visitors or persons admitted for temporary work purposes are antibody negative; there are a number of countries which bar entry to those who cannot prove that they are negative if they will be residing in that country for a significant period of time. These latter entry requirements would not appear to apply to employees who merely "travel" to such countries.

It remains to be seen whether the other two exceptions to be permitted by the Commission will be supported by the weight of medical opinion. The danger of transmission by surgeons who might cut themselves in the course of performing operations may appear to be obvious, but there are surgical techniques now in use which do not involve use of instruments such as scalpels. The basis for requiring that employees whose work affects the safety of the public be free of HIV infection may be particularly questionable. The Commission supports this exception with the statement that HIV infection may lead to damage to the brain and central nervous system and alleges that this symptom may occur at any time. The Commission's rationale thus appears to be based on a chain of reasoning that combines facts and assumptions. Employees who are infected will <u>probably</u> develop the disease; <u>some</u> of those who do may develop these particular symptoms; in a <u>few</u> cases the symptoms may develop without warning. Whether there is a likelihood of the combination of all these possibilities occurring together often enough to constitute a significant

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risk will be only the threshold question. The further question, whether the risk is of sufficient magnitude to justify a general requirement that all employees in these jobs must prove that they are not infected, may well be the subject of some debate. Monitoring of these employees for any sign of the loss or diminution, from whatever cause, of the faculties necessary to perform such jobs, may be found to be sufficient.

The Commission has also stated that it will not accept cases where health care workers are accused of discriminating against AIDS infected patients by refusing to treat them, if the risk to those workers was "real" even when proper medical procedures were followed. Both the Surgeon General of the United States and the Royal Society of Canada, however, have declared that the evidence does not show that such a risk exists, and the basis for this element of the Commission's policy will have to be closely examined.

HEALTH AND SAFETY PROVISIONS

Health and safety legislation at both the federal and provincial levels also permits employees, with certain narrow exceptions, to refuse to perform work in unsafe conditions. This legislation would add an additional layer of protection for employees such as health care workers who refused to work with AIDS or HIV-infected patients if the risk was found to be significant.

In cases where employees have refused to work in those circumstances, however, most of the refusals have been found to be unjustified on the ground that the situation posed no danger. Where a danger has been found, the employer has been ordered to take appropriate precautions or remedial actions, as would be the result in any case where there had been a finding of an unsafe work condition. These cases have thus followed and affirmed the opinion referred to above that the presence of AIDS or HIV infection does not in itself create an "unsafe" workplace, even where contact with the infected person may involve exposure to blood or other bodily fluids, provided standard medical protocols are followed.

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PARLIAMENTARY ACTION

Although there has been no indication to date that the federal government has any plans to introduce legislation dealing with AIDS, the Department of Justice has affirmed that it is considering whether the provisions of the Criminal Code are adequate to deal with behaviour that risks transmitting the HIV virus, and whether an AIDS-specific offence should be created. Mr. Rob Nicholson, the Member of Parliament for Niagara Falls, has, however, tabled a Private Member's Bill which would establish such an offence. This bill was given first reading on 2 May 1988.

The bill does not specify any particular conduct which would be prohibited, but rather would make it an offence to do "anything" which exposed someone else to the risk of transmission of the HIV virus. The offender would first of all have to know that he or she was infected with the virus. The act would then have to be done "knowingly." Presumably what is intended is that no act would be an offence unless the person knew that the act risked transmitting the virus; this element of the bill could perhaps be made clearer.

It may be questioned whether everyone can be presumed to be sufficiently knowledgeable about the ways in which HIV infection is spread, for criminal liability to be assigned in all cases where the offence might apply, when the provision itself does not describe the specific behaviour which poses a danger. The bill may thus be open to the criticism that the full extent of its application is not sufficiently clear. Since, however, to be liable, a person must know that the act for which he or she might be charged could transmit the virus, any element of vagueness would be resolved in favour of the accused.

The bill would appear to indicate that any punishment to be levied would have to include imprisonment, with the power to fine the offender being available only when the fine would be added to a jail sentence.

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The bill provides that if sexual intercourse is involved, it would be a defence to the charge that the person had disclosed his or her infected state to the partner and that the partner knowingly consented to the risk of exposure to the virus. The burden of establishing the defence would be on the accused. This provision is, as noted earlier, an element of most of the AIDS-specific offences which have been passed or are being considered in other jurisdictions.

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